FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0046755

Facility Name: Oakview

Address: 2311 Veterans Drive (Number) Effingham (City) 62401 (Zip Code)

County: Effingham

Telephone Number: (217) 342-6400 **Fax #** (217) 342-6412

IDPA ID Number: 370845492001

Date of Initial License for Current Owners: 03/24/2005

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Michael W.Martin **Telephone Number:** (217) 753-3858
Please send copies of desk review and audit adjustments to address on this page

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 03/24/2005 to 09/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/24/2005

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	3,056	6
7	16	TOTALS	16	3,056	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	1,076		1,324	2,400	13
14	TOTALS	1,076		1,324	2,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.53%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 03/24/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/24/2005 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 06/30/06 Fiscal Year: 06/30/06

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 **Report Period Beginning:** 03/24/2005 **Ending:** 09/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	21,718	2,931	695	25,344		25,344		25,344			1
2	Food Purchase		16,477		16,477		16,477	(1,208)	15,269			2
3	Housekeeping	5,643	5,566		11,209		11,209		11,209			3
4	Laundry	3,740	1,647		5,387		5,387		5,387			4
5	Heat and Other Utilities			8,214	8,214		8,214		8,214			5
6	Maintenance	2,779	4,648	2,783	10,210		10,210		10,210			6
7	Other (specify):*											7
8	**TOTAL General Services**	33,880	31,269	11,692	76,841		76,841	(1,208)	75,633			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,383	1,142	11,971	17,496		17,496		17,496			10
10a	Therapy		171	5,369	5,540		5,540		5,540			10a
11	Activities	63,277	2,429		65,706		65,706		65,706			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation		3,024		3,024		3,024		3,024			14
15	Other (specify):* Day training transp.			224	224		224		224			15
16	**TOTAL Health Care and Programs**	67,660	6,766	17,564	91,990		91,990		91,990			16
	C. General Administration											
17	Administrative	14,472			14,472		14,472		14,472			17
18	Directors Fees											18
19	Professional Services			4,209	4,209		4,209		4,209			19
20	Dues, Fees, Subscriptions & Promotion			136	136		136		136			20
21	Clerical & General Office Expense	19,568	8,944	3,154	31,666		31,666		31,666			21
22	Employee Benefits & Payroll Taxe			46,935	46,935		46,935	1,208	48,143			22
23	Inservice Training & Educatior			468	468		468		468			23
24	Travel and Seminar			121	121		121		121			24
25	Other Admin. Staff Transportatior		461		461		461		461			25
26	Insurance-Prop.Liab.Malpractice			4,171	4,171		4,171	1,926	6,097			26
27	Other (specify):*											27
28	**TOTAL General Administration**	34,040	9,405	59,194	102,639		102,639	3,134	105,773			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	135,580	47,440	88,450	271,470		271,470	1,926	273,396			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakview #0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			4,111	4,111		4,111	15,078	19,189			30
31	Amortization of Pre-Op. & Org											31
32	Interest							18,658	18,658			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			48,993	48,993		48,993	(48,993)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			53,104	53,104		53,104	(15,257)	37,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			14,777	14,777		14,777		14,777			42
43	Other (specify):* Nonallowable Costs											43
44	TOTAL Special Cost Centers			14,777	14,777		14,777		14,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	135,580	47,440	156,331	339,351		339,351	(13,331)	326,020			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,110)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,110)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,221)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,221)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (13,331)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oakview
Provider #: 0046755
03/24/2005 to 09/30/2005 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

Oakview

ID# 0046755

Report Period Beginning: 03/24/2005

Ending: 09/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakview # 0046755 **Report Period Beginning:** 03/24/2005 **Ending:** 09/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,926	0	0	0	0	0	0	0	0	0	1,926	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,926	0	0	0	0	0	0	0	0	0	1,926	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	1,926	0	0	0	0	0	0	0	0	0	1,926	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Oakview** **#** **0046755** **Report Period Beginning:** **03/24/2005** **Ending:** **09/30/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**(6,110)**	**21,188**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15,078**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**18,658**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**18,658**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**(48,993)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(48,993)**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**(6,110)**	**(9,147)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(15,257)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(6,110)**	**(7,221)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(13,331)**	**45**

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARC-Community Support		N/A		CRA Home	Effingham	CILA
Systems, Inc	100			KC Home	Effingham	CILA
				Duplex	Teutopolis	CILA
				DT Center	Teutopolis	Developmental
						Training
				ARC-Community Support Systems		Lessor
	0			Foundation, Inc.	Teutopolis	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	26	Insurance	$	ARC-Community Support Systems Foundation, Inc	0.00%	$ 1,926	$ 1,926	1
2	V	30	Depreciation		ARC-Community Support Systems Foundation, Inc	0.00%	21,188	21,188	2
3	V	32	Interest Expense		ARC-Community Support Systems Foundation, Inc	0.00%	18,658	18,658	3
4	V	34	Rent	48,993	ARC-Community Support Systems Foundation, Inc			(48,993)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 48,993			$ 41,772	$ * (7,221)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached list of Board of Directors.		Management	0.00	0	See Sch. 7A			0		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Oakview
Provider #: 0046755
03/24/2005 to 09/30/2005 **Schedule 7A**

VII. RELATED PARTIES

NOTE: Board of

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 9/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Teutopolis State Bank		X	Facility	$5,100.00	01/31/05	$ 860,000	$ 842,958	03/01/08	0.0375	$ 18,658	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,100.00		$ 860,000	$ 842,958			$ 18,658	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 860,000	$ 842,958			$ 18,658	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Oakview **#** 0046755 **Report Period Beginning:** 03/24/2005 **Ending:** 09/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004	N/A	12

Facility is a not for profit entity and does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakview COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0046755

CONTACT PERSON REGARDING THIS REPORT Dick Reimers

TELEPHONE 618-857-3186 FAX #: 618-857-6343

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? N/A YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,200 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	63,000	2004	$ 95,244	1
2					2
3	TOTALS			$ 95,244	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2005	2005	$ 1,113,035	$	40	$ 13,913	$ 13,913	$ 13,913	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wall and window hangings, drapes, decorating			2005	5,521		10	276	276	276	9
10	Telephone system upgrade			2005	450		10	11	11	11	10
11											11
12											12
13	Landscaping Improvements			2005	957		10	48	48	48	13
14	Fire Sprinklers			2005	10,359		10	518	518	518	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,130,322	$		$ 14,766	$ 14,766	$ 14,766	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	44,504	4,111	3,824	(287)	5-10	3,824	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 44,504	$ 4,111	$ 3,824	$ (287)		$ 3,824	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Use	2002 Ford Van	2005	$ 11,981	$	$ 599	$ 599	5	$ 599	76
77										77
78										78
79										79
80	TOTALS			$ 11,981	$	$ 599	$ 599		$ 599	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,282,051	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,111	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,189	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,078	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 19,189	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 0 Description: N/A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits

(c) For in-house training programs only. Do not include fringe benefits

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	18	$	1,142	$	18	$ 1,142	1
2	Licensed Speech and Language Development Therapist	10A(2), (3)	hrs		63		4,067	171	63	4,238	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs		2		160		2	160	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	83	$	5,369	$ 171	83	$ 5,540	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Oakview
Provider #: 0046755
03/24/2005 to 09/30/2005 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 **Report Period Beginning:** 03/24/2005 **Ending:** 09/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance none)	99,459	99,459	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 99,459	$ 99,459	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,244	13
14	Buildings, at Historical Cost		1,113,035	14
15	Leasehold Improvements, at Historical Cost	957	17,287	15
16	Equipment, at Historical Cost		56,485	16
17	Accumulated Depreciation (book methods)		(19,189)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 957	$ 1,262,862	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 100,416	$ 1,362,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	203,288	203,288	36
37	Accrued Rent	20,997	20,997	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 224,285	$ 224,285	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		842,958	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 842,958	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 224,285	$ 1,067,243	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (123,869)	$ 295,078	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 100,416	$ 1,362,321	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(123,869)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (123,869)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (123,869)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 213,660	1
2	Discounts and Allowances for all Level		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 213,660	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	1,822	24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,822	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 215,482	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	76,841	31
32	Health Care	91,990	32
33	General Administratior	102,639	33
	B. Capital Expense		
34	Ownership	53,104	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	14,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 339,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	(123,869)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (123,869)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. 6 month cost report. No tax return filed for this period.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	345	345	4,383	12.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,986	5,986	63,277	10.57	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,226	2,226	21,718	9.76	15
16	Dishwashers					16
17	Maintenance Worker	259	259	2,779	10.73	17
18	Housekeepers	578	578	5,643	9.76	18
19	Laundry	383	383	3,740	9.77	19
20	Administrator	312	312	7,899	25.32	20
21	Assistant Administrator					21
22	Other Administrative	150	150	6,573	43.82	22
23	Office Manager					23
24	Clerical	1,525	1,525	19,568	12.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	11,764	11,764	$ 135,580 *	$ 11.52	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	34	$ 695	L1, C3	35
36	Medical Director	7	1,750	L10, C3	36
37	Medical Records Consultant	Monthly	20	L10, C3	37
38	Nurse Consultant	413	9,753	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	Monthly	245	L10, C3	46
47	Eye Exams & Dentist	5	203	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	459	$ 12,666		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barb Rodgers	Administrator	0	$ 7,899
Dick Reimers	Exec. Director	0	3,478
Mike Poe	Asse. Exec. Director	0	3,095
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 14,472

B. Administrative - Other

Description	Amount
n/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Am. Express Tax & Bus. Services	Accounting	$ 2,021
KBA Primier	Accounting	210
ADP	Payroll services	1,341
Alliance Benefit	Accounting	75
Clifton Gunderson Solutions	Computer consulting	144
M&F Retirement Services	Benefits consulting	65
Hance, Utz & Associates	Environmental consulting	320
Wabash Independent	Technical consulting	33
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,209

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	10,392
Employee Health Insurance	23,024
Employee Meals	1,208
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plan	179
Dental Insurance	696
Miscellaneous Employee Benefits	9,426
Other Insurance	3,015
Life Insurance	203
TOTAL (agree to Schedule V, line 22, col.8)	$ 48,143

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 24)	80
Miscellaneous Subscription Fees	56
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	121
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 121

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakview # 0046755 Report Period Beginning: 03/24/2005 Ending: 09/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$ N/A	$	$	$	$	$
2													
3													
4			N/A										
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **No**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politic action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **N/A** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **14,777**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **Yes** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **1,208** Has any meal income been offset agains related costs? **No** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **87%**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **Mark R. Kenter, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **No** If no, please explain **6/30/2005 audit is not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

Oakview
Provider #: 0046755
03/24/2005 to 09/30/2005 **Schedule 23A**

XX. GENERAL INFORMATION
Question 12

NOTE: Facility has performed three distinct time studies during three separate weeks to determine how to allocate employee between the various departments in which they perform duties. Facility allocates wages and related taxes and benef the information obtained during these time studies. **However, the facility's third shift has all been allocated to re**

SEE ACCOUNTANTS' COMPILATION REPORT

time

fits based upon

esident services.

RECONCILIATION REPORT **04:03 PM** **8/4/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-13,331	equal to	-13,331	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	18,658	equal to	18,658	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	19,189	equal to	19,189	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	5,540	equal to	5,540	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	171	equal to	171	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	76,841	equal to	76,841	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	91,990	equal to	91,990	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	102,639	equal to	102,639	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	53,104	equal to	53,104	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	0	equal to	0	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	14,777	equal to	14,777	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	4,383	equal to	4,383	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	63,277	equal to	63,277	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	21,718	equal to	21,718	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	2,779	equal to	2,779	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	5,643	equal to	5,643	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	3,740	equal to	3,740	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	14,472	equal to	14,472	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	19,568	equal to	19,568	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	135,580	equal to	135,580	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	695	< or = to	695	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,750	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	9,773	< or = to	11,971	-2,198	O.K.	Pg20 X14..X16+	B. & C.	I7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	14,472	equal to	14,472	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	4,209	equal to	4,209	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	48,143	equal to	48,143	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	136	equal to	136	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	121	equal to	121	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	14,777	equal to	14,777	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,208	< or = to	1,208	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,208	equal to	1,208	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-7,221	equal to	-7,221	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	842,958	equal to	842,958	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	95,244	equal to	95,244	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,130,322	equal to	1,130,322	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	56,485	equal to	56,485	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	19,189	equal to	19,189	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-123,869	equal to	-123,869	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-123,869	equal to	-123,869	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	100,416	equal to	100,416	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Oakview
IDPA Comparative Data - Per Resident Day Cost
Year Ending 09/30/2005

Enter your HSA # in next column =====> 1
Census (Pulls from Page 2) 2,400

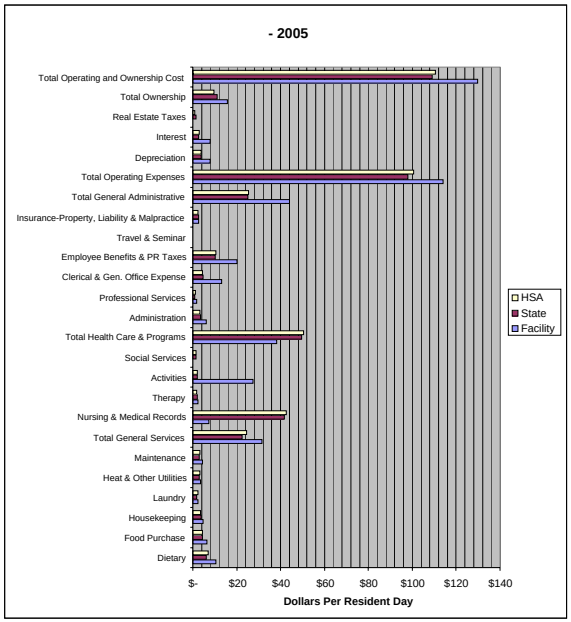
Cost Report Line	Description	Your Facility	Average Median Cost Per Day State	HSA
1	Dietary	10.56	6.10	7.02
2	Food Purchase	6.36	4.31	4.47
3	Housekeeping	4.67	3.70	3.59
4	Laundry	2.24	1.85	2.23
5	Heat & Other Utilities	3.42	2.95	3.17
6	Maintenance	4.25	3.01	3.26
8	Total General Services	31.51	22.58	24.49
10	Nursing & Medical Records	7.29	41.83	42.52
10A	Therapy	2.31	2.10	1.86
11	Activities	27.38	1.91	2.18
12	Social Services	-	1.42	1.45
16	Total Health Care & Programs	38.33	49.48	50.39
17	Administration	6.03	3.36	3.33
19	Professional Services	1.75	0.99	1.09
21	Clerical & Gen. Office Expense	13.19	4.79	4.32
22	Employee Benefits & PR Taxes	20.06	10.09	10.42
24	Travel & Seminar	0.05	0.08	0.10
26	Insurance-Property, Liability & Malpractice	2.54	2.58	2.47
28	Total General Administrative	44.07	24.94	25.31
29	Total Operating Expenses	113.92	98.06	100.77
30	Depreciation	8.00	3.70	3.82
32	Interest	7.77	2.54	2.81
33	Real Estate Taxes	-	1.38	0.92
37	Total Ownership	15.77	11.11	9.73
	Total Operating and Ownership Cost	129.68	#####	110.50

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the **State** and your **HSA** is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	**TOTAL GENERAL SERVICES**	**22.58**	**24.49**	**22.99**	**21.14**	**22.99**	**21.47**	**22.65**	**22.65**	**22.65**	**22.45**	**24.49**	**21.73**	**17.57**	**31.51**
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	**TOTAL HEALTH CARE & PROGRAMS**	**49.48**	**50.39**	**51.22**	**46.39**	**51.22**	**41.58**	**52.34**	**52.34**	**52.34**	**54.96**	**50.39**	**49.49**	**32.10**	**77.23**
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	**TOTAL GENERAL ADMINISTRATIVE**	**24.94**	**25.31**	**26.11**	**23.02**	**26.11**	**21.37**	**25.81**	**25.81**	**25.81**	**26.59**	**25.31**	**22.93**	**16.95**	**39.14**
29	**TOTAL OPERATING EXPENSES**	**98.06**	**100.77**	**100.03**	**92.47**	**100.03**	**88.05**	**100.96**	**100.96**	**100.96**	**103.01**	**100.77**	**94.71**	**69.40**	**142.56**
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	**TOTAL OWNERSHIP**	**11.11**	**9.73**	**9.80**	**8.00**	**9.80**	**7.04**	**14.54**	**14.54**	**14.54**	**11.02**	**9.73**	**8.39**	**3.76**	**23.58**
	TOTAL OPERATING & OWNERSHIP CC	**109.17**	**110.50**	**109.83**	**100.47**	**109.83**	**95.09**	**115.50**	**115.50**	**115.50**	**114.03**	**110.50**	**103.10**	**73.16**	**166.14**



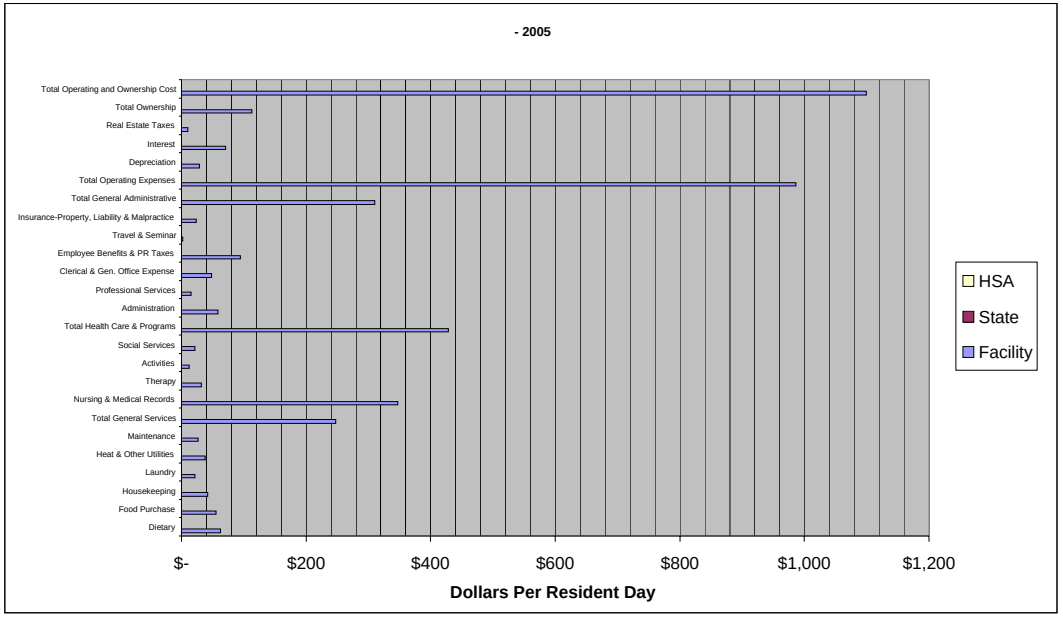
Enter your HSA # in next column: 1
Census (Pulls from Page 2): 2,400

IDPA Comparative Data - Per Resident Day Cost
Year Ending

Cost Report Line	Description	2005 Per Diem Your Facility	2004 Median Cost Per Day State	2004 Median Cost Per Day HSA	2004 Per Diem Your Facility	2004 Median Cost Per Day State	2004 Median Cost Per Day HSA	2003 Per Diem Your Facility	2003 Median Cost Per Day State	2003 Median Cost Per Day HSA	2002 Per Diem Your Facility	2002 Mediam Cost Per Day State	2002 Mediam Cost Per Day HSA
1	Dietary	62.89	-	-	#DIV/0!	-	-	#DIV/0!	6.01	7.28	#DIV/0!	6.01	7.28
2	Food Purchase	55.31	-	-	#DIV/0!	-	-	#DIV/0!	4.27	4.52	#DIV/0!	4.27	4.52
3	Housekeeping	42.21	-	-	#DIV/0!	-	-	#DIV/0!	3.65	3.84	#DIV/0!	3.65	3.84
4	Laundry	21.38	-	-	#DIV/0!	-	-	#DIV/0!	1.90	2.15	#DIV/0!	1.90	2.15
5	Heat & Other Utilities	37.87	-	-	#DIV/0!	-	-	#DIV/0!	2.71	2.84	#DIV/0!	2.71	2.84
6	Maintenance	26.91	-	-	#DIV/0!	-	-	#DIV/0!	2.99	3.41	#DIV/0!	2.99	3.41
8	Total General Services	247.12	-	-	#DIV/0!	-	-	#DIV/0!	22.09	24.39	#DIV/0!	22.09	24.39
10	Nursing & Medical Records	347.29	-	-	#DIV/0!	-	-	#DIV/0!	40.68	42.79	#DIV/0!	40.68	42.79
10A	Therapy	32.12	-	-	#DIV/0!	-	-	#DIV/0!	1.85	1.90	#DIV/0!	1.85	1.90
11	Activities	12.66	-	-	#DIV/0!	-	-	#DIV/0!	1.88	2.12	#DIV/0!	1.88	2.12
12	Social Services	21.45	-	-	#DIV/0!	-	-	#DIV/0!	1.44	1.46	#DIV/0!	1.44	1.46
16	Total Health Care & Programs	428.65	-	-	#DIV/0!	-	-	#DIV/0!	47.55	50.19	#DIV/0!	47.55	50.19
17	Administration	59.01	-	-	#DIV/0!	-	-	#DIV/0!	3.39	3.49	#DIV/0!	3.39	3.49
19	Professional Services	15.41	-	-	#DIV/0!	-	-	#DIV/0!	0.98	1.00	#DIV/0!	0.98	1.00
21	Clerical & Gen. Office Expense	48.35	-	-	#DIV/0!	-	-	#DIV/0!	4.58	4.07	#DIV/0!	4.58	4.07
22	Employee Benefits & PR Taxes	94.10	-	-	#DIV/0!	-	-	#DIV/0!	9.63	10.11	#DIV/0!	9.63	10.11
24	Travel & Seminar	1.91	-	-	#DIV/0!	-	-	#DIV/0!	0.09	0.12	#DIV/0!	0.09	0.12
26	Insurance-Property, Liability & Malpractice	23.30	-	-	#DIV/0!	-	-	#DIV/0!	2.19	1.93	#DIV/0!	2.19	1.93
28	Total General Administrative	310.47	-	-	#DIV/0!	-	-	#DIV/0!	23.47	23.64	#DIV/0!	23.47	23.64
29	Total Operating Expenses	986.24	-	-	#DIV/0!	-	-	#DIV/0!	94.39	99.26	#DIV/0!	94.39	99.26
30	Depreciation	28.85	-	-	#DIV/0!	-	-	#DIV/0!	3.53	3.13	#DIV/0!	3.53	3.13
32	Interest	70.75	-	-	#DIV/0!	-	-	#DIV/0!	2.73	2.84	#DIV/0!	2.73	2.84
33	Real Estate Taxes	10.00	-	-	#DIV/0!	-	-	#DIV/0!	1.30	0.77	#DIV/0!	1.30	0.77
37	Total Ownership	113.25	-	-	#DIV/0!	-	-	#DIV/0!	11.44	9.19	#DIV/0!	11.44	9.19
	Total Operating and Ownership Cost	1,099.49	-	-	#DIV/0!	-	-	#DIV/0!	#####	108.45	#DIV/0!	105.83	108.45

Notes:
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

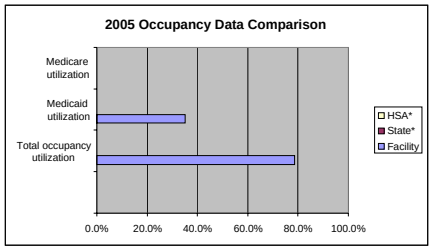
The 2003 & 2002 Median Cost Per Day for the **State** and your **HSA** is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



Oakview
Comparative Occupancy Data
Year Ending 09/30/2005
HSA 1

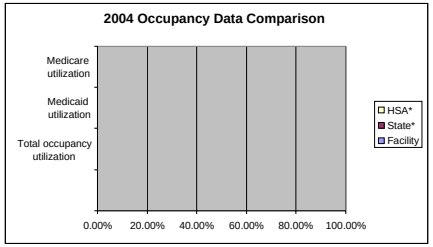
2005

	Your Facility	State*	HSA*
Total occupancy utilization	78.53%	0.00%	0.00%
Medicaid utilization	35.21%	0.00%	0.00%
Medicare utilization	0.00%	0.00%	0.00%
Private pay percent utilization	#VALUE!	N/A	N/A
Capacity in Patient Days	3,056	N/A	N/A
Census days of service provided	2,400	N/A	N/A



2004

	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	0.00%	0.00%
Medicaid utilization		0.00%	0.00%
Medicare utilization		0.00%	0.00%
Private pay percent utilization		N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A

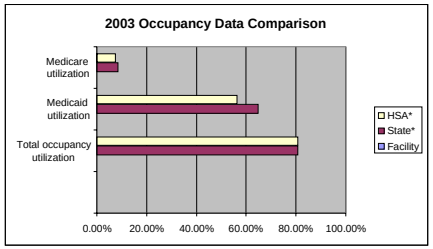


* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

Oakview
Comparative Occupancy Data
Year Ending
HSA 1

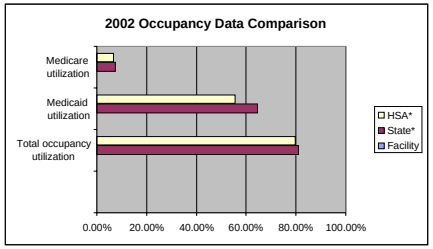
2003

	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.80%	80.80%
Medicaid utilization		64.80%	56.40%
Medicare utilization		8.50%	7.50%
Private pay percent utilization		N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A



2002

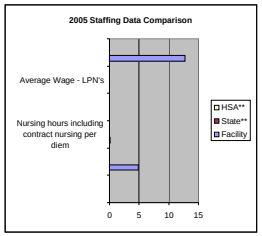
	Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.90%	79.60%
Medicaid utilization		64.50%	55.50%
Medicare utilization		7.40%	6.80%
Private pay percent utilization		N/A	N/A
Capacity in Patient Days		N/A	N/A
Census days of service provided		N/A	N/A



Oakview
Comparative Staffing Data
Year Ending 09/30/2005
HSA 1

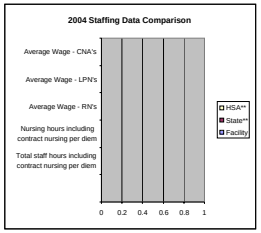
2005

	Your Facility	State**	HSA**
Total staff hours including contract nursing per diem	4.90	0.00	0.00
Nursing hours including contract nursing per diem	0.14	0.00	0.00
Average Wage - RN's		0.00	0.00
Average Wage - LPN's		0.00	0.00
Average Wage - CNA's	12.7	0.00	0.00



2004

	Your Facility	State**	HSA**
Total staff hours including contract nursing per diem		0.00	0.00
Nursing hours including contract nursing per diem		0.00	0.00
Average Wage - RN's		0.00	0.00
Average Wage - LPN's		0.00	0.00
Average Wage - CNA's		0.00	0.00

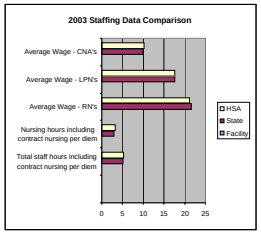


** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

Oakview
Comparative Staffing Data
Year Ending 09/30/2005
HSA 1

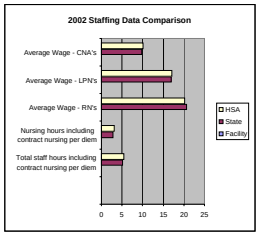
2003

	Your Facility	State	HSA
Total staff hours including contract nursing per diem		5.10	5.30
Nursing hours including contract nursing per diem		2.90	3.20
Average Wage - RN's		21.56	21.14
Average Wage - LPN's		17.64	17.65
Average Wage - CNA's		9.91	10.11

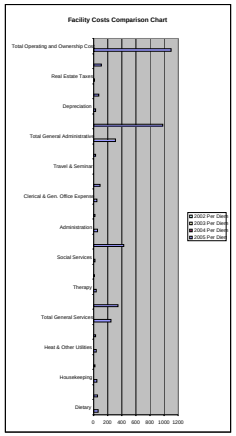


2002

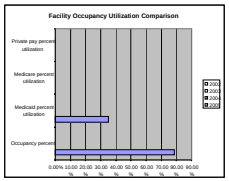
	Your Facility	State	HSA
Total staff hours including contract nursing per diem		5.20	5.50
Nursing hours including contract nursing per diem		2.80	3.10
Average Wage - RN's		20.69	20.12
Average Wage - LPN's		16.89	17.04
Average Wage - CNA's		9.73	10.05

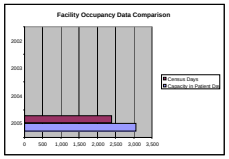


Cost Report Line	Description	Year Facility 2005 Per Diem	Year Facility 2004 Per Diem	Year Facility 2003 Per Diem	Year Facility 2002 Per Diem
1	Dietary	62.89	#DIV/0!	#DIV/0!	#DIV/0!
2	Food Purchase	55.31	#DIV/0!	#DIV/0!	#DIV/0!
3	Housekeeping	42.21	#DIV/0!	#DIV/0!	#DIV/0!
4	Laundry	21.38	#DIV/0!	#DIV/0!	#DIV/0!
5	Heat & Other Utilities	37.87	#DIV/0!	#DIV/0!	#DIV/0!
6	Maintenance	26.91	#DIV/0!	#DIV/0!	#DIV/0!
8	Total General Services	247.12	#DIV/0!	#DIV/0!	#DIV/0!
10	Nursing & Medical Records	247.29	#DIV/0!	#DIV/0!	#DIV/0!
10A	Therapy	32.12	#DIV/0!	#DIV/0!	#DIV/0!
11	Activities	12.66	#DIV/0!	#DIV/0!	#DIV/0!
12	Social Services	21.45	#DIV/0!	#DIV/0!	#DIV/0!
16	Total Health Care & Programs	428.65	#DIV/0!	#DIV/0!	#DIV/0!
17	Administration	59.01	#DIV/0!	#DIV/0!	#DIV/0!
19	Professional Services	15.41	#DIV/0!	#DIV/0!	#DIV/0!
21	Clerical & Gen. Office Expense	48.35	#DIV/0!	#DIV/0!	#DIV/0!
22	Employee Benefits & PR Taxes	94.10	#DIV/0!	#DIV/0!	#DIV/0!
24	Travel & Seminar	1.91	#DIV/0!	#DIV/0!	#DIV/0!
26	Insurance-Property, Liability & Malpract	23.30	#DIV/0!	#DIV/0!	#DIV/0!
28	Total General Administrative	310.47	#DIV/0!	#DIV/0!	#DIV/0!
29	Total Operating Expenses	986.24	#DIV/0!	#DIV/0!	#DIV/0!
30	Depreciation	28.85	#DIV/0!	#DIV/0!	#DIV/0!
32	Interest	70.75	#DIV/0!	#DIV/0!	#DIV/0!
33	Real Estate Taxes	10.60	#DIV/0!	#DIV/0!	#DIV/0!
37	Total Ownership	113.25	#DIV/0!	#DIV/0!	#DIV/0!
	Total Operating and Ownership Cost	1,099.49	#DIV/0!	#DIV/0!	#DIV/0!

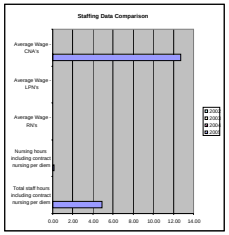


	Facility 2005	Facility 2004	Facility 2003	Facility 2002
Occupancy percent	78.53%	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid percent utilization	35.21%	0.00%	0.00%	0.00%
Medicare percent utilization	0.00%	0.00%	0.00%	0.00%
Private pay percent utilization	#VALUE!	0.00%	0.00%	0.00%
Capacity in Patient Days	3,056	0	0	0
Census Days	2,400	0	0	0





	Facility 2005	Facility 2004	Facility 2003	Facility 2002
Total staff hours including contract nursing per dis	4.90	0.00	0.00	0.00
Nursing hours including contract nursing per diem	0.14	0.00	0.00	0.00
Average Wage - RN's		0.00	0.00	0.00
Average Wage - LPN's		0.00	0.00	0.00
Average Wage - CNA's	12.70	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	21,718	2,931	695	25,344	0	25,344	0	25,344
2. Food Purchase	0	16,477	0	16,477	0	16,477	(1,208)	15,269
3. Housekeeping	5,643	5,566	0	11,209	0	11,209	0	11,209
4. Laundry	3,740	1,647	0	5,387	0	5,387	0	5,387
5. Heat and Other Utilities	0	0	8,214	8,214	0	8,214	0	8,214
6. Maintenance	2,779	4,648	2,783	10,210	0	10,210	0	10,210
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	33,880	31,269	11,692	76,841	0	76,841	(1,208)	75,633
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	4,383	1,142	11,971	17,496	0	17,496	0	17,496
10a. Therapy	0	171	5,369	5,540	0	5,540	0	5,540
11. Activities	63,277	2,429	0	65,706	0	65,706	0	65,706
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	3,024	0	3,024	0	3,024	0	3,024
15. Other (specify)*	0	0	224	224	0	224	0	224
16. Total Health Care & Programs	67,660	6,766	17,564	91,990	0	91,990	0	91,990
17. Administrative	14,472	0	0	14,472	0	14,472	0	14,472
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	4,209	4,209	0	4,209	0	4,209
20. Fees, Subscriptions & Promotion	0	0	136	136	0	136	0	136
21. Clerical & General Office	19,568	8,944	3,154	31,666	0	31,666	0	31,666
22. Employee Benefits & Payroll	0	0	46,935	46,935	0	46,935	1,208	48,143
23. Inservice Training & Education	0	0	468	468	0	468	0	468
24. Travel and Seminar	0	0	121	121	0	121	0	121
25. Other Admin. Staff Trans	0	461	0	461	0	461	0	461
26. Insurance-Prop.Liab.Malpractice	0	0	4,171	4,171	0	4,171	1,926	6,097
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	34,040	9,405	59,194	102,639	0	102,639	3,134	105,773
29. Total General Administrative	135,580	47,440	88,450	271,470	0	271,470	1,926	273,396
30. Depreciation	0	0	4,111	4,111	0	4,111	15,078	19,189
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	18,658	18,658
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	48,993	48,993	0	48,993	(48,993)	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	53,104	53,104	0	53,104	(15,257)	37,847
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	14,777	14,777	0	14,777	0	14,777
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	0	14,777	14,777	0	14,777	0	14,777
45. Grand Total	135,580	47,440	156,331	339,351	0	339,351	(13,331)	326,020

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	99,459	99,459
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	99,459	99,459
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	95,244
14. Buildings, at Historical Cost	0	1,113,035
15. Leasehold Improvements, Historical Cost	957	17,287
16. Equipment, at Historical Cost	0	56,485
17. Accumulated Depreciation (book methods)	0	-19,189
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	957	1,262,862
25. Total Assets	100,416	1,362,321
CURRENT LIABILITIES		
26. Accounts Payable	0	0
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	203,288	203,288
37. Other Current Liabilities (specify):	20,997	20,997
38. Total Current Liabilities	224,285	224,285
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	842,958
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	842,958
46.Total Liabilities	224,285	1,067,243
47.Total Equity	-123,869	295,078
48.Total Liabilities and Equity	100,416	1,362,321

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	213,660
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	213,660
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	1,822
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	1,822
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	215,482
31. General Services	76,841
32. Health Care	91,990
33. General Administration	102,639
34. Ownership	53,104
35. Special Cost Centers	0
35. Provider Participation Fee	14,777
37. Other	0
40. Total Expenses	339,351
41. Income Before Income Taxes	-123,869
42. Income Taxes	0
43. Net Income or Loss for the Year	-123,869

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IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2005 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary														
2	Food Purchase														
3	Housekeeping														
4	Laundry														
5	Heat & Other Utilities														
6	Maintenance														
8	**TOTAL GENERAL SERVICES**														
10	Nursing & Medical Records														
10A	Therapy														
11	Activities														
12	Social Services														
16	**TOTAL HEALTH CARE & PROGRAMS**														
17	Administration														
19	Professional Services														
21	Clerical & Gen. Office Expense														
22	Employee Benefits & PR Taxes														
24	Travel & Seminar														
26	Insurance-Property, liability & Malpractice														
28	**TOTAL GENERAL ADMINISTRATIVE**														
29	**TOTAL OPERATING EXPENSES**														
30	Depreciation														
32	Interest														
33	Real Estate Taxes														
37	**TOTAL OWNERSHIP**														
	TOTAL OPERATING & OWNERSHIP COST														

2005 - Average Wage Data Table

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem												
Nursing hours including contract nurses per diem												
RN												
LPN												
CNA												
DON												
ADON												

2005 - Staffing and Occupancy Data

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy												
Medicaid Utilization												
Medicare Utilization												

		2004 Costs	2004 Census
Cost Report Line	Description		
1	Dietary		
2	Food Purchase		
3	Housekeeping		
4	Laundry		
5	Heat & Other Utilities		
6	Maintenance		
8	**TOTAL GENERAL SERVICES**		
10	Nursing & Medical Records		
10A	Therapy		
11	Activities		
12	Social Services		
16	**TOTAL HEALTH CARE & PROGRAMS**		
17	Administration		
19	Professional Services		
21	Clerical & Gen. Office Expense		
22	Employee Benefits & PR Taxes		
24	Travel & Seminar		
26	Insurance-Property, liability & Malpractice		
28	**TOTAL GENERAL ADMINISTRATIVE**		
29	**TOTAL OPERATING EXPENSES**		
30	Depreciation		
32	Interest		
33	Real Estate Taxes		
37	**TOTAL OWNERSHIP**		
	TOTAL OPERATING & OWNERSHIP COST		

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary														
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33	Real Estate Taxes														
37	**TOTAL OWNERSHIP**														
	TOTAL OPERATING & OWNERSHIP COST														

2004 - Average Wage Data Table

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem												
Nursing hours including contract nurses per diem												
RN												
LPN												
CNA												
DON												
ADON												

2004 - Staffing and Occupancy Data

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy												
Medicaid Utilization												
Medicare Utilization												

		2004 Costs	2004 Census
Cost Report Line	Description		
1	Dietary		
2	Food Purchase		
3	Housekeeping		
4	Laundry		
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17	Administration		
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22	Employee Benefits & PR Taxes		
24	Travel & Seminar		
26	Insurance-Property, liability & Malpractice		
28	**TOTAL GENERAL ADMINISTRATIVE**		
29	**TOTAL OPERATING EXPENSES**		
30	Depreciation		
32	Interest		
33	Real Estate Taxes		
37	**TOTAL OWNERSHIP**		
	TOTAL OPERATING & OWNERSHIP COST		

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004) UN-INFLATED

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	**TOTAL GENERAL SERVICES**	**22.58**	**24.49**	**22.99**	**21.14**	**22.99**	**21.47**	**22.65**	**22.65**	**22.65**	**22.45**	**24.49**	**21.73**	**17.57**	**31.51**
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	**TOTAL HEALTH CARE & PROGRAMS**	**49.48**	**50.39**	**51.22**	**46.39**	**51.22**	**41.58**	**52.34**	**52.34**	**52.34**	**54.96**	**50.39**	**49.49**	**32.10**	**77.23**
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	**TOTAL GENERAL ADMINISTRATIVE**	**24.94**	**25.31**	**26.11**	**23.02**	**26.11**	**21.37**	**25.81**	**25.81**	**25.81**	**26.59**	**25.31**	**22.93**	**16.95**	**39.14**
29	**TOTAL OPERATING EXPENSES**	**98.06**	**100.77**	**100.03**	**92.47**	**100.03**	**88.05**	**100.96**	**100.96**	**100.96**	**103.01**	**100.77**	**94.71**	**69.40**	**142.56**
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	**TOTAL OWNERSHIP**	**11.11**	**9.73**	**9.80**	**8.00**	**9.80**	**7.04**	**14.54**	**14.54**	**14.54**	**11.02**	**9.73**	**8.39**	**3.76**	**23.58**
	TOTAL OPERATING & OWNERSHIP COST	**109.17**	**110.50**	**109.83**	**100.47**	**109.83**	**95.09**	**115.50**	**115.50**	**115.50**	**114.03**	**110.50**	**103.10**	**73.16**	**166.14**

2003 Costs **2003 Census**

Cost Report Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	**TOTAL GENERAL SERVICES**
10	Nursing & Medical Records
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17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	**TOTAL GENERAL ADMINISTRATIVE**
29	**TOTAL OPERATING EXPENSES**
30	Depreciation
32	Interest
33	Real Estate Taxes
37	**TOTAL OWNERSHIP**
	TOTAL OPERATING & OWNERSHIP COST

2003 - Average Wage Data Table

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.20	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14	20.33
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65	16.45
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11	9.76
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67	24.62
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.67	22.50

2003 - Staffing and Occupancy Data

	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%	77.30%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%	59.30%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%	8.00%